LOST WAGES/EARNINGS CLAIM FORM

THIS FORM IS TO BE COMPLETED BY THE VICTIM

CVR NUMBER: _____ Victim Name: _____

Claimant Name: _____

Your claim investigator is: _____ Phone #: _____

NOTE: The CVR board does NOT guarantee full payment of your lost wages.

LOST WAGES CAN ONLY BE CLAIMED BY THE VICTIM

STEP 1. GATHER THE FOLLOWING DOCUMENTATION TO VERIFY LOST WAGES/EARNINGS

1. Have your employer complete the VERIFICATION FORM.
2. If you missed more than one week of work, you must have your physician complete the attached DISABILITY VERIFICATION form and attach it to the claim form when complete. Otherwise, only one week can be reimbursed.
3. If you are self-employed, you must copy your tax return from the year of the crime incident and any contract, bids, estimates, or other documents which might help verify your earnings and attach them to this claim form.
4. If you are not self-employed, you must have your employer complete the attached EMPLOYMENT/WAGES VERIFICATION FORM. You must also include with your claim your last tax return and/or W-2 or 3-4 pay stubs.
5. Proof of disability income.

STEP 2. ANSWER THE FOLLOWING QUESTIONS ABOUT LOST WAGES/EARNINGS

1. Dates absent from work due to crime-related injuries?

   From ___/____/____ to ____/_____/____ = _____ Total Weeks Absent

2. Lost Wages/Earnings lost per week = $ _____ X _____ = $ _____***Lost Wage Total***
   Wkly Wage Wks out work

3. Did you miss more than one week of work? [ ] Yes [ ] No
   If yes, your physician must complete the DISABILITY VERIFICATION form. If no, explain on the back of this form.

4. Were the loss of wages/earnings partially covered in part/full by any of the following sources? _____

   If yes: Beginning Date _____ Ending Date _____

   Amounts received per week/month: _____

   [ ]Union coverage [ ]Disability insurance [ ]Workers' Compensation [ ]Sick Pay

   [ ] Vacation Pay [ ]Unemployment [ ]Other, (specify) _____

   Complete the following information for all insurance and/or benefits plans that might cover this loss:

   Company Name _____ Phone:_____

   Policy Number _____ Group Number _____

   Address: _____
   (Street, City, State, & Zip Code)

   NOTE: IF ANY TYPE OF COVERAGE IS AVAILABLE, YOU MUST APPLY FOR THOSE BENEFITS BEFORE FILING WITH THE CVR PROGRAM.

SEND THIS FORM & ATTACHMENTS TO**:**

STEP 3. SIGN HERE: _____

DATE: _____